Appendix D: Forms to Copy

The following forms can be copied and used by the provider as needed:

Accommodation and Room Rates Schedule
Adjustment Request Form (with instructions)
(AND) Administratively Necessary Day Intake Form
Authorization for Electronic Funds Transfer
Certificate of Medical Necessity (CMS 484, with instructions)
Change of Provider Information Authorization Form
Compound Detail NDC Attachment
Dental Prior Authorization Form – General
Dental Prior Authorization Form – Orthodontics
Disclosure Of Ownership And Control Interest Statement
Durable Medical Equipment/Supplies Request Form
Electronic Claims Submission Certification and Authorization
Electronic PA Request Attachment Cover Sheet
Group Affiliation Roster
Hospice Intake Form
Individual Affiliation Roster
Interceptive Request Form
Medical Necessity Form (pregnancy related)
NDC Detail Attachment
Personal Care Services Progress Notes (with instructions)
Request for Additional Crisis Case Management Hours
Request for Taxpayer Identification Number and Certification (W-9)
Signature-on-File Form
Surgery Prior Authorization Request
Transportation Request (with instructions)
Vision Prior Authorization Request

(Note: To print a form, select print from the Acrobat Reader tool bar and select "current page" or enter the page range.)

Forms to Order from EDS

The following forms can be ordered from EDS. See the next page for ordering instructions.

Drug Claim Form	352-023
Finger Print Card	FD258
Notice of Admit or Discharge: NF or ICF/MR	HW0458
PASARR Screen Form	HW0087
PCS Assessment and Care Plan	RMU 14.01
Physicians Medical Care Evaluation for PCS	HW0603 3/98
QMRP Assessment	HW0615
QMRP Visit	HW0621
Sterilization Consent Form	HW0034
Visit Notes for Supervising Nurses	HW0620

Order Form Instructions

Use this form to order any of the forms listed from EDS.

- Copy this page as needed.
- Enter your provider name and Idaho Medicaid number
- Enter the quantity needed
- Complete the 'Send to' section. This will be used as the mailing label for your order. Please print.
- Indicate if the materials should be sent to the attention of a person or department.
- After completing the order form, mail it to:

  EDS
  P.O. Box 23
  Boise, ID 83707

Forms can also be ordered by phone. Call MAVIS at (800) 685-3757. Ask for *AGENT.*

Provider Name: _____

Idaho Medicaid Provider Number: _____

	Form Name	Form Number	Quantity
☐	Drug Claim Form	352-023	
☐	Finger Print Card	FD258	
☐	Notice of Admit or Discharge: NF or ICF/MR	HW0458	
☐	PASARR Screen Form	HW0087	
☐	PCS Assessment and Care Plan	RMU 14.01	
☐	Physicians Medical Care Evaluation for PCS	HW0603 3/98	
☐	QMRP Assessment	HW0615	
☐	QMRP Visit	HW0621	
☐	Self Declaration for Criminal History	HW0284	
☐	Sterilization Consent Form	HW0034	
☐	Visit Notes for Supervising Nurses	HW0620	

From: EDS
P.O. Box 23
Boise, ID 83707

Send to: _____

_____

_____

_____

Attention: _____

Name of Institution _____

Idaho Medicaid Provider Number _____ Total number of licensed hospital beds _____

Enter the usual and customary rate and the effective date for each applicable accommodation revenue code. Only the codes listed may be updated. This schedule is not required for Dialysis Units.

Authorized Signature _____Date _____

Name printed or typed: _____

Return to: EDS
Provider Enrollment **Fax: (208) 395-2198**
P.O. Box 23
Boise, ID 83707

Revenue Code	Accommodations	Rate	Effective Date
101	All Inclusive Room/Board		
111	Medical / Surgical / GYN		
112	Obstetric		
113	Pediatric		
114	Psychiatric		
116	Detoxification		
117	Oncology		
118	Rehabilitation		
120	Semi-Private		
121	Medical / Surgical / GYN		
122	Obstetric		
123	Pediatric		
124	Psychiatric		
126	Detoxification		
127	Oncology		
128	Rehabilitation		
130	Semi-Private		
131	Medical / Surgical / GYN		
132	Obstetric		
133	Pediatric		
134	Psychiatric		
136	Detoxification		
137	Oncology		
138	Rehabilitation		
140	Private		

Revenue Code	Accommodations	Rate	Effective Date
141	Medical / Surgical / GYN		
142	Obstetric		
143	Pediatric		
144	Psychiatric		
146	Detoxification		
147	Oncology		
148	Rehabilitation		
150	Room and Board - Ward		
151	Medical / Surgical / GYN		
152	Obstetric		
153	Pediatric		
154	Psychiatric		
156	Detoxification		
157	Oncology		
158	Rehabilitation		
164	Sterile Environment		
170	Nursery		
171	Newborn		
172	Premature		
173	Neo-Natal Intensive Care Level III		
174	Neo-Natal Intensive Care Level IV		
200	Intensive Care Unit		
201	Surgical		
202	Medical		
203	Pediatrics		
204	Psychiatric		
207	Burn Care		
208	Trauma		
210	Coronary Care Unit		
211	Myocardial Infarction		
212	Pulmonary Care		
213	Heart Transplant		

Mail to: EDS
PO Box 23
Boise, ID 83707

Do not fax this form

Information: (800) 685-3757

Adjustment Request Form

1. Provider Medicaid Number: _____

2. Prov. Name: _____

3. Prov. Address: _____

_____ ZIP _____

4. Claim ICN: _____

5. Client Medicaid Number: _____

6.Client Name: _____

7. RA Number: _____

8. RA Date: _____

9. Correct Billing Information:

Claim Line (optional)	Incorrect information on claim	Correct information for adjustment

10. Requested Action:

☐ I am refunding the overpayment (attach check made out to: **State of Idaho**).

☐ Please withhold overpayment in a future Medicaid warrant with an adjustment.

☐ Please pay me more in a future warrant due to an underpayment by Medicaid.

11. Signature: _____ Date: _____

EDS use only Related History ICN: _____

Action: _____

Adjustment Request Form Instructions

This Adjustment Request Form can be duplicated for use as needed. When making copies, it is not necessary to copy these instructions also. Adjustment requests must be mailed. Please do **not** fax this form.

1. Provider Medicaid Number: enter your 9-digit Medicaid provider identification number. Do **not** use a Social Security or FEIN number. This number is in the upper left-hand corner of the first page of your remittance advice (RA).
2. Prov. Name: enter your provider name. This is in the lower right-hand corner of the first page of your RA.
3. Prov. Address: enter your mailing address. This is in the lower right-hand corner of the first page of your RA.
4. Claim ICN: This is the unique 15-digit claim identification number. It is found on the Paid Claim page of your RA following the client's MID.
5. Client Medicaid Number (MID): enter the 7-digit client Medicaid Identification Number. It is found on the Paid Claim page of your RA following the client's name. Do not use a Social Security number.
6. Client Name: enter the client's name as it is on the RA. It is found on the Paid Claim page of your RA.
7. RA Number: This is in the upper right-hand corner of the first page of your RA.
8. RA Date: enter the date from the RA. This is at the top of the first page of your RA.
9. Correct Billing Information: simply and clearly state what the correct billing information should have been on the claim. If a line of a claim needs to be corrected, enter the line number from the claim form. Enter what was wrong on the line and the correct information to replace it.

   Example: a claim is incorrectly billed with 100 units on line 4 and, after the claim is submitted, the provider receives a check from other insurance. The correct number of units is 10 and the insurance amount is $1124.47. Complete the form as shown:

Claim Line (optional)	Incorrect information on claim	Correct information for adjustment
4	*100 units billed*	*Correct number of units is 10*
		Other insurance paid $1124.47

10. Requested Action: select the appropriate box. If you owe a refund to Medicaid because of an overpayment, you can send a check for the amount or request that the overpayment be deducted from future warrants. Make checks payable to: **State of Idaho**.
11. Signature: the person who completes this form must sign and date it.

Adjustments may be initiated by:

- Providers to correct claims submission or processing errors
- EDS to recoup incorrect payments
- DHW for recoupments or retroactive rate adjustments

Adjusted claims are grouped together in the RA by provider service location. Each service location has a separate section. Within provider service location, the adjusted claims are sorted by client last name. Grand totals are calculated for adjustment claim totals and a total net adjustment amount is calculated to reflect the net effect of all adjustments.

(AND) ADMINISTRATIVELY NECESSARY DAY INTAKE FORM

FAX TO: Idaho Medicaid, Bureau of Medical Care

(208) 332-7280

Date	
Requesting Agency Name	
Contact Person	
Phone #	
Fax #	
Address	
Hospital Medicaid Provider #	
Attending Physician	
Hospital admission date	
Patient Name	
Medicaid #	
Diagnosis	
ICD-9 Codes	
Reason for AND Request	
AND Dates requested	
Supporting Documents Required – please attach the following	☐ Summary of patient's medical condition ☐ Current History and Physical ☐ Physician progress notes ☐ Statement as to why patient can not receive necessary medical services in a non-hospital setting □ ☐ Documentation that the hospital has diligently made every effort to locate a facility or organization to deliver appropriate services □
MEDICAID USE ONLY	
# of AND Approved	
Dates Approved	
Authorization #	
Request Denied	
Reason Denied	
Log Completed by Staff Signature	

Authorization for Electronic Funds Transfer

Complete all the sections below **if** you wish to have your payments automatically deposited to your bank. The transaction routing number can be obtained from your bank.

Important: you must include a letter from your bank verifying your transaction routing number and account number. For deposits to a checking account, you may instead include an original voided check or copy of a voided check. If you include a voided check, tape it in the space provider below. (Please do **not** staple the check.)

Provider Name	
Bank Name	**Bank Phone Number**
Bank Address	
Account Number	
Transaction Routing Number (nine digit) ___ ___ ___ ___ ___ ___ ___ ___ ___	
Type of Account (circle only one) **Checking** **Savings**	

I authorize the electronic transfer of Idaho Medicaid payments made to the above provider. I understand that I am responsible for the validity of the above information.

Authorized signature: _____

Name typed or printed: _____

Idaho Medicaid provider number: _____

Date: _____

Mail to: **EDS**
Provider Enrollment
P.O. Box 23
Boise, ID 83707

Fax to: **EDS**
Attn: Provider Enrollment
(208) 395-2198

Information: (800) 685-3757

For checking account deposit only,
tape a voided check here.

Certificate of Medical Necessity (CMS 484, with instructions-2 pages)

(pdf form – get copy from previous version of Provider CD or obtain copy from http://new.cms.hhs.gov/CMSForms/CMSForms/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS007682 and insert in pdf version of this files.)

(Placeholder for Certificate of Medicate Necessity instructions)

Change of Provider Information Authorization Form

Provider Number:	**Provider Name:**
Date requested information is effective:	
Please change the information for the following name(s) or address(es): _____ Pay-to _____ Mail-to _____ Service Location(s)	
Old Name	New Name (attach a signed W-9 with effective date if Pay-To name is changing)
Old Address:	New Address:
Old Telephone Number:	New Telephone Number:
Old Tax ID Number:	New Tax ID Number: (attach a signed W-9 with effective date)
Additional Comments	
Provider Signature: **Date Signed:**	

Mail to: **EDS**
Provider Enrollment
P.O. Box 23
Boise, ID 83707

Fax to: **EDS**
Attn: Provider Enrollment
(208) 395-2198

Information: (800) 685-3757

Compound Detail NDC Attachment
(insert a pdf copy)

Idaho Medicaid Dental Program Dental Prior Authorization Form-General			Rev 8/05
Medicaid Client Information			
Last Name:	First Name:		Initial:
Client Medicaid ID Number:	Date of Birth:		
Providing Dentist Name:			
Address:			
City:	State:	Zip Code:	
Phone Number: ( ) -	Provider ID (Medicaid Number):		

Date of Service (if retro review)	Tooth	Procedure Code	Description

Remarks:

Place of Service (Check the appropriate box)

□ **Office** □ **Hospital** □ **Long-Term Care Facility** □ **Ambulatory surgical Center** □ **Other**

Replacement: □ Yes □ No	**Enclosures:** □ Pano □ X-Ray □ Model(s)

(Department Use Only) Do not write in boxes below

Procedure(s) being authorized or denied:

Authorized: □	**Denied**: □	**Reviewer(s) Initials**:	**PA Number:**

IDAPA Reference:

Mail to: Division of Medicaid
Attn: Dental Unit
PO Box 83720
Boise, ID 83720-0036

Idaho Medicaid Dental Program
Dental Prior Authorization Form-Orthodontics Rev. 9/05

Medicaid Client Information

Last Name	First Name	Initial

Client Medicaid Number	Date of Birth

Provider Name

Address

City	State	Zip Code

Phone Number ( )	Provider ID (Medicaid Number)

Dentition ☐ Primary ☐ Adolescent

☐ Transitional ☐ Adult

Please check box to indicate if additional information is attached to the prior authorization form

Treatment Summary Notes ☐ Attached

Key Factors in Treatment ☐ Attached

Probable Treatment Plan ☐ Attached

Procedure Code(s)

Enclosures ☐ **Pano** ☐ **X-Ray** ☐ **Model(s)**

(Department use only) Do not write in boxes below

Procedure(s) being authorized or denied

Authorized ☐	**Denied** ☐	**Reviewer(s) Initials**	**PA Number**

Mail to: Division of Medicaid
Attn: Dental Unit
PO Box 83720
Boise, ID 83720-0036

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Providers must disclose to the State Medicaid Agency the following information:

❶ Enter the legal name of your business: _____

❷ Check (√) the applicable Business Category:
□ Sole Proprietor □ Corporation □ Partnership □ Limited Liability Corporation □ Government

❸
A) List the name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more (42 CFR §§ 455.104).
B) List any board members not already listed.
C) Indicate with a check (√) in the applicable column if the person listed has ever been sanctioned, excluded, or convicted of a criminal offense related to Medicare, Medicaid, or any Federal agency or program (42 CFR §§ 455.106).

A & B	**C**		
Name and Address	Sanctioned	Excluded	Convicted

❹ Are any of the persons named above related as spouse, parent, child or sibling to any of the other persons named? □ Yes □ No If Yes, provide name(s) of person(s) and relationship(s).

_____

❺ Do any of the persons listed in # 3 have ownership or control interest of 5% or more in other organizations that bill Medicaid for services? □ Yes □ No If Yes, provide the following for each organization.

Organization Legal Business Name	FEIN	Medicaid Provider Number

_____ _____
Provider Signature Date

IDAHO MEDICAID DME/SUPPLIES REQUEST FORM

State of Idaho **Department of Health & Welfare** **Division of Medicaid** **PO Box 83720** **Boise, ID 83720-0036** **1-866-205-7403**	**URGENT** **YES NO**	**DEPARTMENTAL USE ONLY**
Provider Name:		

Contact Person:	**Phone: ( )**	**Fax: ( )**	**Provider Number:**
Provider Address:	**City:**	**State:**	**Zip:**
Client Name:	**Client MID:**		**DOB:**
Client Address:	**City:**	**State:**	**Zip:**
Physician Name/Address:			
Insurance Information:		**Diagnosis:**	
Healthy Connections Physician:	**Healthy Connections Referral #:**		

DESCRIPTION	HCPCS Code	QUANTITY	START DATE	STOP DATE	PRICE	Rental/Purchase

Please attach all appropriate medical necessity and pricing documentation to support the request

FAX: 1-800-352-6044

_____, hereinafter referred to as 'Provider', hereby certifies as follows:
(Provider name)

The provider certifies that all services and items for which reimbursement will be claimed shall be furnished by, or under the supervision of, the Provider.

The Provider understands that the use of electronic claims submission does in no way relieve the Provider of responsibilities for (a) maintaining such medical and fiscal records as are necessary to disclose fully the nature and extent of services or items provided by the Provider to Medicaid recipients, and making such records available upon request to the Department of Health and Welfare (DHW) and the United States Department of Health and Human Services; and (b) promptly returning to the Department of Health and Welfare, or its fiscal agent, the amount of any erroneous or excess payments received for services or items provided to any Medicaid recipients.

The Provider certifies that the claim is due; that the Provider is authorized to sign for the payee; that complete records of these services are being kept in hardcopy form for five (5) years and will be provided upon request. The Provider accepts payment in full for the claims submitted subject to adjustment as authorized by Department regulations and certifies that these services have been rendered without unlawful discrimination on the grounds of race, age, sex, creed, color, national origin, or physical or mental handicap. The Provider certifies that if prescription services are provided, a legal prescription is on file for each medication issued.

The Provider certifies that all services and items from which reimbursement will be claimed shall be provided in accordance with all Federal and State laws pertaining to the Idaho Medicaid Program, and that all charges submitted for services and items provided shall not exceed Provider's usual and customary charges for the same services and items when provided to persons not entitled to receive benefits under the Idaho Medicaid Program.

The Provider understands that any payments made in satisfaction of claims submitted will be derived from Federal and State funds and that any false claims, statements, or documents, or concealment of material fact may be subject to prosecution under applicable Federal and State law.

If the Provider uses a billing service, the provider agrees to report completely and accurately to the billing service all information necessary to ensure compliance with Federal and State laws pertaining to the Idaho Medicaid Program, as amended.

The Provider understands that the Department reserves the right to revoke its approval for electronic claims submission, at any time, for failure on the part of the Provider or billing service to comply fully with any or all guidelines governing the submission of electronic claims.

The Provider holds EDS harmless and indemnifies EDS against any liability to the Provider, the State of Idaho, or to any Medicaid Provider arising out of the entering into this agreement or subsequent receiving and processing of Medicaid claims by tape or other electronic media.

SECTION I

DHW shall allow Providers to enter Medicaid claims through the claims entry system developed by the Department's fiscal agent and designated Electronic Claims Submission (ECS), or through the use of entry screens developed by authorized computer vendors, or by magnetic tape or cartridge.

Both EDS and the State of Idaho must approve of any provider **prior** to the submission of electronic claims.

The Provider shall allow the Department access to claims data and assure that submission of claims data is restricted to authorized personnel so as to preclude erroneous payments resulting from carelessness or fraud.

Continued on page 2

Provider Name: _____

Provider Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____

Authorized Signature: _____ Date: _____

Name printed or typed _____

SECTION II

(To be completed by Providers using a Billing Service)

The Provider agrees to abide by the policies affecting electronic submissions as published in the electronic specification manual for Medicaid claims.

The Provider hereby certifies that _____ is authorized to
(Billing Service)
submit electronic claims on Provider's behalf.

The Provider agrees that if the billing arrangement with the aforementioned billing service is terminated, the Provider will immediately report the termination in writing to the Department or its fiscal agent.

Authorized Signature _____ Date _____

Name printed or typed _____

Mail to: **EDS**
Provider Enrollment
P.O. Box 23
Boise, ID 83707

Fax to: **EDS**
Attn: Provider Enrollment
(208) 395-2198

Information: (800) 685-3757
Ask for Provider Enrollment

Idaho Medicaid
Electronic PA Request Attachment Cover Sheet

Complete and submit this cover sheet with the required attachment when you submit an electronic HIPAA formatted Prior Authorization Request (HIPAA 278 transaction). We will match the information on this cover sheet with your electronic PA request.

This cover sheet is not required for PAs that are not requested electronically.

Please provide the following information:

Prior Authorization Control # Note – This number must match the control number required on the PA request	
Date electronic PA request was submitted	
Provider Name	
Provider 9-digit ID Number	
Client Name	
Client's 7-digit Medicaid ID Number	
Date(s) of Service	

Group Affiliation Roster

This page is used by groups to affiliate individual Medicaid providers with the group. Providers must be enrolled as individuals **before** they can be affiliated with a group. If more space is need, copy this page and complete the listing. Listing a provider on this roster does **not** enroll the individual in the Idaho Medicaid program. Do **not** list individuals who will not be furnishing Medicaid services or who are not enrolled as Medicaid providers.

NOTE: Each provider listed on this roster must sign and date this sheet. No other person can be authorized to sign for an individual provider.

Group Name _____ **Group number** _____

Individual Provider Name	Idaho Medicaid Individual Provider Number	Individual Provider Signature	Date Signed	Date Effective

Mail to: **EDS**
Provider Enrollment
P.O. Box 23
Boise, ID 83707

Fax to: **EDS**
Attn: Provider Enrollment
(208) 395-2198

Information: (800) 685-3757

HOSPICE INTAKE FORM

FAX TO: Idaho Medicaid, Bureau of Medical Care at (208) 332-7280

Today's Date	
REQUESTING AGENCY INFORMATION	
Hospice Contact Person	
Name of Hospice	
Hospice Idaho Medicaid Provider Number	
Address	
Phone #	
Fax #	
PATIENT INFORMATION	
Name of Patient	Date of birth:
Idaho Medicaid Number	
Address of Current Residence	
Check one of the following	☐ Skilled Nursing Facility ☐ Intermediate Care Facility for Mentally Retarded ☐ Own Home ☐ Certified Home
Date of Hospice Election	
Date of Death/Revoke	
Diagnosis	
ICD-9 Codes	
Check all of the following that apply – Patient has coverage including	☐ Medicare ☐ A&D Wavier (Aged and Disabled) ☐ DD Wavier (Developmentally Disabled) ☐ PCS (Personal Care Service) ☐ Other in-home care, specify: ☐ Healthy Connections No ☐ Yes ☐
Supporting Documents Required – please attach the following	☐ Signed Hospice Election Form ☐ Current History and Physical ☐ Physician Orders for Hospice ☐ Hospice Care Plan ☐ Healthy Connections Physician Referral Number: _____
Ordering Physician	☐ Physician is hospice agency employee ☐ Physician is hospice volunteer ☐ Physician is private practitioner

Revised: 10/07/2002

Individual Affiliation Roster

This roster is used by individual providers who wish to affiliate with a group (or groups) already enrolled in the Idaho Medicaid program. Providers must be enrolled as individuals **before** they can be affiliated with a group. Being included in a group enrollment **does not** enroll the individual with Medicaid.

Do **not** complete this page if you are an individual provider not affiliated with a group practice.

NOTE: Listing a group on this form does **not** enroll the group in the Idaho Medicaid program.

NOTE: The individual provider must sign and date this sheet. No other person can be authorized to sign for an individual provider.

Group Name	Idaho Medicaid Group Provider Number	Date Signed	Date Effective

I wish to be affiliated with the above listed group(s) in the Idaho Medicaid program.

Signature: _____

Name typed or printed: _____

Provider Medicaid identification number: _____

Date: _____

Mail to: EDS
Provider Enrollment
P.O. Box 23
Boise, ID 83707

Fax to: **EDS**
Attn: Provider Enrollment
(208) 395-2198

Information: (800) 685-3757

Idaho Medicaid Dental Program
EPSDT Request Form - INTERCEPTIVE Orthodontics 03/06

Medicaid Client Information

Last Name	First Name	Initial

Client Medicaid Number	Date of Birth

Provider Name

Address

City	State	Zip Code

Phone Number ( )	Provider ID (Medicaid Number)

Dentition ☐ **Primary**

☐ **Transitional**

UPPER Arch Treatment Plan:

LOWER Arch Treatment Plan:

Length of Treatment:

Requested Procedure Code (with arch designation):

Enclosures: ☐ **Panograph** ☐ **Models** (if not previously reviewed)

(Department use only. Do not write in boxes below)

Procedure(s) being authorized or denied by Department:

Authorized ☐	Denied ☐	Reviewer's Initials	Number

Mail to: Division of Medicaid
Attn: Dental Unit
PO Box 83720
Boise, ID 83720-0036

Medical Necessity Form (pregnancy related)

Client Name:_____

Client Medicaid Identification Number: _____

Date of Service: _____

Describe How Service is Pregnancy Related:

_____

_____

_____

_____

_____

Provider signature: _____

Name typed or printed: _____

Idaho Medicaid Provider number:_____

Date: _____

Mail to: **EDS**
P.O. Box 23
Boise, ID 83707

Information: (800) 685-3757

IDAHO DEPARTMENT OF HEALTH & WELFARE

NDC Detail Attachment

This form is a required attachment for any Idaho Medicaid paper claim billed using a drug HCPCS code on a CMS-1500 or a UB-92

PROVIDER NAME_____ PROVIDER NUMBER_____

CLIENT NAME_____ CLIENT ID NUMBER_____ DATE(s) OF SERVICE_____

LINE	NDC	DESCRIPTION	UNITS	BASIS OF MEASUREMENT			TOTAL CHARGES
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$
				GR	ML	UN	$

Please fill in:

- The corresponding line number from the CMS-1500 (HCFA-1500) or the UB-92
- The NDC number used
- The drug description
- The actual quantity (units) given to the patient
- Check the appropriate basis of measurement
- The unit price for the NDC

Personal Care Services Progress Notes

PCS Provider _____ Medicaid Provider Number _____

Client Name _____ Client Medicaid Number (MID) _____

Client Address _____ Client Phone Number _____

I certify that the data on this form is accurate and correct.

Provider Signature _____ Date _____

Client Signature _____ Date _____

Date	Bath	Shampoo	Shave	Grooming/Oral care	Dressing/undressing	Bladder/bowel	Nail care	Ambulate	ROM: active/passive	Turn/position	Meal preparation	Feeding	Grocery shopping	Linen change	Laundry	Vacuum	Dust	Mop/sweep	Empty trash	Clean bathroom	Clean kitchen	Empty catheter bag	Clean BSD, leg bag	Therapy	Transportation	Supervising nurse	Other	Time in	Time out	Total hours

Date	Observations, changes, problems

Personal Care Services Progress Notes Instructions

Personal care services providers are required to supply their own forms for Personal Care Services Progress Notes. Providers may make copies of the form on the reverse side of these instructions, create their own version containing the required information pursuant to the Rules Governing Medical Assistance, IDAPA 16.03.09.146.11, or make copies of the older form Alternative Care Services HW 0609 (2/88).

A copy of the client's progress notes shall be maintained in the client's home unless authorized to be kept elsewhere by the RMS. Failure to maintain such documentation may result in the recoupment of funds paid for undocumented services.

The following instructions are for the PCS Progress Notes.

Please make copies of this form as needed. It is **not necessary** to include these instructions unless desired by the user.

Instructions

PCS Provider: enter your provider name. This is in the lower right-hand corner of the first page of your remittance advice (RA).

Provider Medicaid Number: enter your 9-digit Medicaid provider identification number. Do **not** use a Social Security or FEIN number. This number is in the upper left-hand corner of the first page of your RA.

Client Name: enter the client's name as it is on the RA. It is found on the Paid Claim page of your RA.

Client Medicaid Number (MID): enter the 7-digit client Medicaid Identification Number. It is found on the Paid Claim page of your RA following the client's name. Do not use a Social Security number.

Client Address: enter the address at which the Medicaid client lives.

Client Phone Number: if the client has a home telephone, enter the number.

Provider Signature/Date: the person who completes this form must sign and date it.

Client Signature/Date: the client who receives the services must sign and date this form, **unless** it is determined by the RMU that the client is unable to do so.

Indicate the date, type of service(s), time in/out, and total hours for all services provided.

Indicate the client's response to the service, including any changes noted in the client's condition. Enter any changes in the treatment plan authorized by the referring physician, other provider, supervising registered nurse, or QMRP as the result of changes in the participant's condition.

REQUEST FOR ADDITIONAL CRISIS SERVICE COORDINATION HOURS

Additional Community Crisis Service Coordination hours are requested in order to facilitate access to emergency community resources, by linking/coordinating, and/or advocating for services. Please complete this form and forward to Bureau of Behavioral Health.

Participant Name: _____ Number of Hours Requested: _____
Medicaid Number: _____
Service Coordinator: Start Date: End Date:

_____ _____ _____

Provider #

Participant must meet all of the following criteria:

- **Imminent risk (within 14 days) of hospitalization or institutionalization; and**
- **Experiencing symptoms of psychiatric decompensation; and**
- **Received the maximum number of monthly hours of ongoing and crisis service coordination; and**
- **No other crisis assistance services are available under other Medicaid mental health option services (including) Psychosocial Rehabilitation Services**

Crisis must be precipitated by an unanticipated event, circumstance, or life situation that places the participant at risk of: (check all that apply)

☐ Hospitalization
☐ Incarceration
☐ Becoming homeless
☐ Losing employment or major source of income
☐ Physical harm to self or others (family altercation or psychiatric relapse)

Please document the following information in detail. Attach the service coordination assessment and treatment plan and any applicable progress notes.

1. Presenting Problem:

A. Date crisis began:
B. Describe the crisis, include the unanticipated event or circumstance that led to the crisis**.**

_____

_____

_____

_____

_____

_____

_____

_____

_____

C. What symptoms of psychiatric decompensation are present?

_____

_____

_____

_____

Division of Medicaid
Bureau of Behavioral Health

Shannon Froehlich, MS
Phone 364-1903 Fax 332-7286
froehlics@idhw.state.id.us

2. Crisis Response History:

MONTH TO DATE TOTALS: Ongoing Service Coordination _____ Crisis Service Coordination _____

A. What linking, coordination, or advocacy services have already been provided to resolve this crisis? (Include the number of ongoing service coordination and crisis units or hours already provided during the calendar month.)

_____
_____
_____
_____

B. How does this intervention promote the health and safety of the recipient or prevent hospitalization/incarceration/out of home placement?

_____
_____
_____
_____

3. Crisis Resolution Plan:

A. Action Plan: What is your agency's response to resolving the crisis? (Be specific and identify what linking, coordinating, or advocacy services will be provided.)

_____
_____
_____
_____

B. How does this intervention promote the health and safety of the recipient or prevent hospitalization/incarceration/out of home placement?

_____
_____
_____
_____
_____
_____
_____
_____
_____

Participant Name: _____ ***Agency Name:*** _____

Phone Number: _____

Signature of Service Coordinator: _____ ***Fax Number:*** _____

Date: _____ ***E-Mail Address:*** _____

Request for Taxpayer Identification Number and Certification (W-9) – 4 pages
(pdf file – obtain from http://www.irs.gov/ and insert in pdf version of this document)

(Placeholder for page 2 of W-9)

(Placeholder for page 3 of W-9)

(Placeholder for page 4 of W-9)

Signature-on-File Form

I hereby certify that I have compared the information submitted regarding materials furnished and services rendered against my records and that the foregoing information is true, accurate, and complete. I further certify that:

- the charges submitted for the material furnished and services rendered are correct charges against the State of Idaho pursuant to applicable Department regulations and State law;
- the claim is due;
- I am authorized to sign for the payee;
- complete records of materials and services will be provided upon request to the Secretary of the United States Department of Health and Human Services; the Idaho Department of Health and Welfare, and the Medicaid Fraud/SUR Section;
- I accept payment as payment in full subject to adjustment in accordance with the Department regulations;
- all materials furnished and/or services rendered have been provided without unlawful discrimination on the grounds of race, age, sex, creed, color, national origin, physical handicap, or mental handicap.

I understand that payment and satisfaction of all claims submitted with my signature will be from Federal and State funds and that any falsification or concealment of material fact is subject to prosecution under applicable Federal and State laws.

I agree and certify that, for all Medicaid claims submitted with the signature of:

_____,

the terms and conditions of the above statement have been met and will continue to be met.

Authorized signature: _____

Name typed or printed: _____

Idaho Medicaid provider number:_____

Date: _____

The provider or responsible corporate official must sign this certificate statement.

Mail to: **EDS**
Provider Enrollment
P.O. Box 23
Boise, ID 83707

Fax to: **EDS**
Attn: Provider Enrollment
(208) 395-2198

Information: (800) 685-3757

MEDICAID SURGERY PRIOR AUTHORIZATION REQUEST

To Requesting Provider: Please complete form, attach required documentation and return.

PRIOR AUTHORIZATION REQUEST FORM

Today's Date:	Proposed Surgery date:
Client:	Hospital:
Medicaid #	Inpatient ☐ Outpatient ☐
DOB:	
Phone:	
Requesting Provider:	Surgeon:
Address:	Address:
City/Zip:	City/Zip:
Phone:	Phone:
FAX:	FAX:
Provider #	Provider #

Procedure Description and Codes_____
_____
_____

Additional Comments_____
_____
_____

Supporting documents required, please attach the following: (mark all items attached)

- ☐ **History and Physical**
- ☐ **Consultations**
- ☐ **Provider/Surgeon notes**
- ☐ **Treatment Plan**
- ☐ **History of Disease**
- ☐ **Present Condition**

Mail or Fax to: Division of Medicaid
Attn: Physician Consultant
PO Box 83720
Boise, Idaho 83720-0036

Phone 208-364-1839
Fax 208-332-7280

Medicaid Non-Emergent Transportation Request

Date/Time | Provider Phone: ( )

Region: | Provider Name: | Provider Fax ( )

Provider #:

Client Information	
Client MID	
Client Name	
Client DOB	
Client Phone	
Client Address	
Client City/State/Zip	
Why Not Driving Self	
Medical Services/Reason For Transport	
Client's Healthy Connections Physician (if applicable)	
Special Transport Needs? (Wheelchair Van)	
Medical Provider Information	
Medical Provider Name	
Medical Provider Phone	
Medical Provider Treatment Address	
Physician Referral Obtained (if service is outside of community)	
Transport Information	
Dates of Service	
Appointment Time	
Initial Blanket Authorization	
Blanket - Days Of The Week	
Pick-Up Address	
Drop Off Address (End of Transport)	
Total Loaded Miles Per Trip	
Services Requested	
Procedure Codes Requested	
Units Requested Per Code	
Price Per Unit	
For Medicaid Use Only	
Approved / Denied	
DB Completed	
PA Completed	

Outside Boise Calling Area
800-296-0513
FAX 800-296-0513

Boise Calling Area 334-4990
FAX# 208-334-4979

Transport Request Form Instructions

Use these instructions to complete the Transport Request Form. Complete all fields on the form.

Field Name	Description of required data
Client Information	
Client MID	Complete 7-digit client Medicaid identification number. It is the responsibility of the requestor to verify current client eligibility prior to making request
Client Name	Name as it appears on the Medicaid ID card
Client DOB	Client's date of birth.
Client Phone	Phone number where client/guardian may be reached for verification of request.
Client Address	Client's actual physical address (residence).
Client City/State/Zip	City, state, zip code for client's address.
Why Not Driving Self	Explain why the client needs state-funded transportation. For example, the client cannot drive due to age, physical disability, there is not a vehicle in the household, or other free resources available such as friends, family members, or charitable organization.
Medical Services/Reason for Transport	Provide only enough information to determine if medical service is a covered benefit. *Example*: "Counseling" is **not** adequate as there are many types of counseling that are not covered such as vocational, marital, etc.
Client's Healthy Connections Doctor (if applicable)	If client is enrolled in Healthy Connections, enter name of primary care provider.
Special Transport Needs? (Wheelchair Van)	Enter special needs for this client such as wheel chair, ambulance, etc.
Medical Provider Information	
Medical Provider Name	Actual name of the clinic or individual medical provider, if a solo practitioner.
Medical Provider Phone	Phone number where appointment can be verified.
Medical Provider Treatment Address	Address where client will be transported to.
Physician Referral Obtained If request is to transport client out of their local community to a distant provider, the following documentation is required ⇒	**From The Referring Physician:** • Diagnosis • Reason for the referral to a distant provider • Statement that equivalent services are not available locally • Brief history of the client's case **From the Distant Receiving Physician:** • Acknowledgement they have accepted this Idaho Medicaid client • Date and time of appointment • Anticipated medical services to be provided • Estimated length of treatment and follow-up visits based on the referral information received from the referring physician • Statement that the medical services to be provided are not available in the client's community or at a closer location Receiving physician understands he/she must contact the Department directly for services requiring prior authorization or extended medical care • Physician's Idaho Medicaid Provider Identification Number (9-digits)
Transport Information	
Dates of Service	From Date: 1st date of transport To Date: last date of transport. This will be the same date unless request was for

	a “blanket authorization” to include several dates.
Appointment Time	Time of appointment
Initial Blanket Authorization	Indicate if this is or is not a blanket request.
Blanket – Days of Week	
Pick-Up Address	Physical address where client will be picked up. May enter “home” if same as client address.
Drop Off Address (End of Transport)	May enter “home” if being returned home.
Total Loaded Miles Per Trip	
Services Requested	
Procedure Codes Requested	Enter the transportation procedure code you will be billing to Medicaid. Check *Notification of Decision* letter when received to be certain mileage and procedure code are correct PRIOR to billing.
Units Requested Per Code	1 unit = 1 mile. Enter total ROUND TRIP miles for this request. If this is a blanket request, enter TOTAL MILEAGE for the entire blanket authorization that would include all trips.
Price Per Unit	Enter the “price per unit” which should appear on the *Notice of Decision* letter calculated with rate chart.

PRIOR AUTHORIZATION REQUEST

Division of Medicaid
Bureau of Medical Care
Vision

FAX TO: (208)-332-7280
PHONE (208) 332-7955

FOR DEPARTMENT USE ONLY

PA Number: _____

Reviewed by: _____

Review Date: _____

PROVIDER NAME: _____

PROVIDER NUMBER: _____ **PHONE NUMBER:** _____

FAX NUMBER:_____

CLIENT NAME: _____

MEDICAID ID: _____ **DATE OF SERVICE:** _____

==========

SERVICE REQUESTED:

HIGH INDEX LENS: _____ **ASPHERIC LENS:** _____ **POLYCARBONATE:** _____

CONTACTS: _____

OTHER:

_____

_____

PLEASE COMPLETE THE RX BELOW OR ATTACH A COPY WITH THIS REQUEST

Rx		Spherical	Cylindrical	Axis	Prism	Base
D.V.	O.D.					
	O.S.					
N.V	O.D.					
	O.S.					

JUSTIFICATION -- DIAGNOSIS -- COMMENTS: _____

_____

_____